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ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD DISCONTINUATION APPLICATION FOR EXEMPTION

DEC 2'0 2018

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATIONS REVIEW BOARD

Facility/Project Ide	entification				THE STANK
Facility Name:	Presence Saint	Joseph Hospital-	Chicago)	
Street Address:	2900 North Lak	e Shore Drive			
City and Zip Code:	Chicago, IL 60	657			
County: Cook	Healt	h Service Area	Vi	Health Planning Are	ea: A-01
Applicant(s) [Prov	ide for each a	applicant (refer	to Par	t 1130.220)j	
Exact Legal Name: Pr	esence Chicago	Hospitals Netwo	rk d/b/a	Presence Saint Jose	ph Hospital-Chicago
Street Address:		200 S. Wacker	Drive, 1	1 th Floor	
City and Zip Code:		Chicago, IL 608			
Name of Registered Ag	gent:	CT Corporation			
Registered Agent Street	et Address:	208 South LaSa	lle Stree	t, Suite 814	
Registered Agent City	and Zip Code:	Chicago, IL 606	04		
Name of Chief Executive	ve Officer:	Mark A. Frey			
CEO Street Address:		2601 Navistar D	rive		
CEO City and Zip Code		Lisle, IL 60532			
CEO Telephone Numb	er:	224/273-4121	·		
Type of Ownershi	p of Applica	nts			
X Non-profit Corp		Ц	Partne		
☐ For-profit Corp		Ц		nmental	C) 045
Limited Liability	y Company		Sole P	roprietorship	☐ Other
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	na iimitea iiabiii	ty companies mu	st provid	le an Illinois certifica	ite oi good
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APPEND DOCUMENT	ATION AS ATT	FACHMENT 1 IN	NUMER	IC SEQUENTIAL OF	DER AFTER THE
LAST PAGE OF THE					
Primary Contact [Person to rec	eive ALL corre	spond	ence or inquiries]	
Name:	Jacob M. Axel				
Title:	President				
Company Name:	Axel & Associa	ates, Inc.			
Address:	675 North Cou	irt, Suite 210 Pal	atine, IL	60067	
Telephone Number:	847/776-7101				
E-mail Address:	jacobmaxel@r	msn.com			
Fax Number:	847/776-7101				
Additional Contact	t [Person wh	o is also autho	rized to	o discuss the appl	ication for
exemption]			_ -	1.1.	
Name:	none				
Title:	TOTIC		-		
Company Name:		·			•
Address:					
Telephone Number:					
E-mail Address:				<u> </u>	
Fax Number:					

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD DISCONTINUATION APPLICATION FOR EXEMPTION

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

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Facility/Project Ide	entification	4				
Facility Name:	Presence Saint	Joseph Hospital	-Chicago	5		
Street Address:	2900 North Lak	e Shore Drive				
City and Zip Code:	Chicago, IL 60					
County: Cook	Healt	h Service Area	VI	Health Planning	Area: A-01	
		l'		± 4420 020\1		
Applicant(s) [Prov	ide for each a	applicant (refe	rio Pai	t 1130.220)]	Co. diblo Ali	ALTA Lippith
Exact Legal Name:	Ale			est Region Health	Co. d/b/a Aiv	III A Health
Street Address:		2601 Navistar	Drive Li	sie		
City and Zip Code:		IL 60532 CT Corporation	Systom			
Name of Registered Ag		208 South LaSa				
Registered Agent Street Registered Agent City	et Address.	Chicago, IL 600		et, Suite 014		
Name of Chief Executive	vo Officer:	Mark A. Frey	304			
CEO Street Address:	ve Officer.	2601 Navistar D	rive			
CEO City and Zip Code	<u> </u>	Lisle, IL 60532	71140			
CEO Telephone Numb		224/273-4121				
CLO Telephone Humb		2242104121		<u> </u>		
Type of Ownershi	in of Annlica	nte				
Type of Ownershi	p oi Applica	1165				
X Non-profit Corp	noration		Partne	ershin		
For-profit Corp		H		nmental		
Limited Liability		П		roprietorship		Other
	y company				_	
 Gorporations a 	ind limited liabili	ty companies mu	st provid	le an Ill <mark>inois cert</mark> i	ficate of god	bo
standing.						
 Partnerships m 	nust provide the	name of the stat	e in whic	ch they are organiz	ed and the r	name and
address of eac	h partner specif	ying whether ead	ch is a g	eneral or limited pa	artner.	
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LAST PAGE OF THE	AFFLICATION	FURIN.	.*			
Primary Contact [Person to rec	eive All corr	enond	ence or inquirie	e]	
Name:	Jacob M. Axel		Sopono	Crioc or miquine	<u></u>	
Title:	President	· · · · · · · · · · · · · · · · · · ·				····-
Company Name:	Axel & Associa	ates Inc				
Address:		irt, Suite 210 Pa	latine II	60067		
Telephone Number:	847/776-7101	ing Carto 210 1 a	<u> </u>			
E-mail Address:	jacobmaxel@i	msn com				
Fax Number:	847/776-7101					
Tax Humber.	0477770 1 101					
Additional Cantas	4 (Doroon wh	a is also suth	orizad f	o discuss the a	nnlication '	for
Additional Contac	it [Person wi	o is also autili	JIIZEU I	U uiscuss lite a	ppilication	IOI
exemption]			<u>.</u>			
Nāmē:	ที่อีกี่ย์					
Title:						
Company Name:						
Address:						
Telephone Number:						
E-mail Address:						

Fax Number:

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD DISCONTINUATION APPLICATION FOR EXEMPTION

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Facility/Project Ide							
Facility Name:	Presence Saint			Chicago)		
Street Address:	2900 North Lak		ive	-			
City and Zip Code:	Chicago, IL 60						
County: Cook	Healt	h Service	Area	Vi	Health Planning A	rea: A-01	
Applicant(s) [Prov	ide for each a				t 1130.220)]		
Exact Legal Name:		Ascensio	n Heal	th			
Street Address:		4600 Edr	nunson	Road			
City and Zip Code:		St. Louis,					
Name of Registered Ag	gent:	Illinois Co					L
Registered Agent Stree	et Address:	801 Adlai			ive		
Registered Agent City	and Zip Code:	Springfield	d, IL 62	2703			
Name of Chief Executive	ve Officer:	Patricia M					
CEO Street Address:		4600 Edm	unson	Road			
CEO City and Zip Code	9 :	St. Louis,	MO 63	3134			
CEO Telephone Numb	er:	314/733-8	000				
Type of Ownershi	p of Applica	nts					
	" - 						
X Non-profit Corp		[Partner			
☐ For-profit Corp	oration	· [Govern			
Limited Liability	y Company	ſ		Sole Pr	roprietorship		Other
standing. o Partnerships m	nust provide the	name of th	e state	in which	e an Illinois certific h they are organized neral or limited parti	d and the n	
APPEND DOCUMENT	ATION AS ATT	ACHMENT FORM.	<u>r 1</u> in 1	NUMER	IC SEQUENTIAL O	RDER AFT	rer the
Primary Contact [I	Person to rec	eive ALL	corre	sponde	ence or inquiries]		
Name:	Jacob M. Axel						
Title:	President						
Company Name:	Axel & Associa						
Address:	675 North Cou	rt, Suite 21	0 Pala	tine, IL	60067		
Telephone Number:	847/776-7101						
E-mail Address:	jacobmaxel@r	nsn.com		•			
Fax Number:	847/776-7101						
Additional Contac	t [Person wh	o is also	authoi	rized to	o discuss the app	olication f	or
exemption]							
Name:	none						
Title:						-	
Company Name:							
Address:	1						
Telephone Number:							
E-mail Address:							

Fax Number:

Post Exemption Contact

[Person to receive all correspondence subsequent to exemption issuance-THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS **DEFINED AT 20 ILCS 3960]**

Name:	Peg Wendell, Esq.	
Title:	Executive Vice President, Chief Legal Officer	
Company Name:	AMITA Health	
Address:	2601 Navistar Drive Lisle, IL 60532	
Telephone Number:	224/273-2333	
E-mail Address:	peg.wendell@amitahealth.org	
Fax Number:	224/273-4121	

Site Ownership

Provide the	s information t	for eacl	h appl	licable	site]
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<u> </u>	
Exact Legal Name of Site Owner:	Presence Chicago Hospitals Network
Address of Site Owner:	200 South Wacker Drive, 11th Fl. Chicago, IL 60606
Street Address or Legal Description	on of the Site: 2900 North Lake Shore Drive Chicago, IL 60657
Proof of ownership or control of	f the site is to be provided as Attachment 2. Examples of proof of
	ements, tax assessor's documentation, deed, notarized statement
of the corporation attesting to ov	wnership, an option to lease, a letter of intent to lease, or a lease.
APPEND DOCUMENTATION AS	ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE
LAST PAGE OF THE APPLICATION	ON FORM.

Operating Identity/Licensee

	ide this information for each a				
Exact	Legal Name: Presence Chicago H	ospitals Netwo	ork d/b/a Presence saint Jo	seph Hospita	al-Chicago
Addres					
X 	Non-profit Corporation For-profit Corporation Limited Liability Company		Partnership Governmental Sole Proprietorship		Other
. 0	Corporations and limited liability of Partnerships must provide the na each partner specifying whether of Persons with 5 percent or great ownership.	me of the stat	e in which organized and the eral or limited partner.	e name and	address of
	ND DOCUMENTATION AS ATTAC		I NUMERIC SEQUENTIAL	ORDER AFI	ER THE

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Narrative Description

In the space below, provide a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

The proposed project is limited to the discontinuation of the open heart surgery category of service ("the service") at Presence Saint Joseph Hospital-Chicago, within thirty days following approval of this Certificate of exemption application.

The service was suspended via a letter dated November 6, 2018, and sent to the Administrator of the Illinois Health Facilities and Services Review Board and the Division Chief of IDPH's Division of Health Care Facilities and Programs.

Project Status and Completion Schedules Outstanding Permits: Does the facility have any projects for which the State Board issued a permit that is not complete? Yes __ No _X_. If yes, indicate the projects by project number and whether the project will be complete when the exemption that is the subject of this application is complete. Anticipated exemption completion date (refer to Part 1130.570): State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:

- X Cancer Registry
- X APORS
- X All formal document requests such as IDPH Questionnaires and Annual Bed Reports been
- XAll reports regarding outstanding permits

Failure to be up to date with these requirements will result in the Application being deemed incomplete.

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);

0	in the case of estates and trusts, two of its beneficiaries do not exist); and	beneficiaries (or the sole beneficiary when two or more
0	in the case of a sole proprietor, the individ	ual that is the proprietor.
Neto in acc The u behalf provid knowle	work d/b/a Saint Joseph Fordance with the requirements and proceed indersigned certifies that he or she has the fof the applicant entity. The undersigned herein, and appended hereto, are contact the contact in the co	esence Chicago Hospitals lospital-Chicago * edures of the Illinois Health Facilities Planning Act. be authority to execute and file this Application on diffurther certifies that the data and information inplete and correct to the best of his or her ertifies that the fee required for this application is
	Julio P. Roknich Julie P. Roknich TED NAME Assistant Secretary TED TITLE	Bettina John Son PRINTED NAME ASSISTANT Treasurer PRINTED TITLE
Subso this //	zation: cribed and sworn to before me day of DEC, 2018 ture of Notary	Notarization: Subscribed and sworn to before me this day of Dec 2018 Signature of Notary Seal
*Inser	ELIZABETH D NEARY Official Seal Notary Public - State of Illinois My Commission Expires Jun 10, 2020 The EXACT legal name of the applicant	ELIZABETH O NEARY Official Seal Notary Public - State of Illinois My Commission Expires Jun 10, 2020

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Alexian Brothers-AHS Midwest Region Health Care Co. d/b/a AMITA Health

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In accordance with the requirements and proced The undersigned certifies that he or she has the behalf of the applicant entity. The undersigned f provided herein, and appended hereto, are comp knowledge and belief. The undersigned also cer sent herewith or will be paid upon request.	authority to execute and file this Application o urther certifies that the data and information lete and correct to the best of his or her
MANURE FUND	SIGNATURE
PRINTED NAME OCSIMAN / CO PRINTED TITLE	PRINTED NAME EVP/CFO PRINTED TITLE
Notarization: Subscribed and sworn to before me this day of Dec. 2016 Signature of Notary Seal	Notarization: Subscribed and sworn to before me this IF day of Dec., 2018 Elimath Diony Signature of Notary Seal
ELIZABETH D NËARY Official Seat Notary Public - State of Illinois	ELIZABETH D NEARY Official Seal Notary Public - State of Illinois My Commission Expires Jun 10, 2020

My Commission Expires Jun 10, 2020

*Insert the EXACT legal name of the applicant

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and

	o in the case of a sole proprietor, the individu	ual that is the proprietor.
	The undersigned certifies that he or she has the behalf of the applicant entity. The undersigned provided herein, and appended hereto, are com-	edures of the Illinois Health Facilities Planning Act. e authority to execute and file this Application on I further certifies that the data and information
	Christine K. McCoy PRINTED NAME Assistant Secretary PRINTED TITLE	SIGNATURE Rhonda Anderson PRINTED NAME Assistant Treasurer PRINTED TITLE
•	Notarization: Subscribed and sworn to before me this 11th day of December Signature of Notary	Notarization: Subscribed and sworn to before me this // day of // JELEM BER Signature of Notary
,	Seal ELFRIEDE M. ROHE Notary Public - Notary Seal STATE OF MISSOURI	Seal PATRICIA D. CHITWOOD Notary Public - Notary Seal

Comm. Number 01505902 St. Louis County My Commission Expires: July 13, 2020

State of Missouri, St Louis County Commission Number 12383265 My Commission Expires Aug 15, 2020

*Insert the EXACT legal name of the applicant

SECTION II. DISCONTINUATION

Type of Discontinuation

	Discontinuation of an Existing Health Care Facility
X	Discontinuation of a category of service

Criterion 1130.525 and 1110.290 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

- 1. Identify the categories of service and the number of beds, if any, that are to be discontinued.
- 2. Identify all of the other clinical services that are to be discontinued.
- 3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
- 4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
- 5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
- 6. For applications involving the discontinuation of an entire facility, provide certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires; capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.
- 7. Provide attestation that the facility provided the required notice of the facility or category of service closure to local media that the health care facility would routinely notify about facility events. The supporting documentation shall include a copy of the notice, the name of the local media outlet, the date the notice was given, and the result of the notice, e.g., number of times broadcasted, written, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.

APPEND DOCUMENTATION AS <u>ATTACHMENT 5</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for the discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.130(b) for examples.

APPEND DOCUMENTATION AS <u>ATTACHMENT 6</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

IMPACT ON ACCESS

- 1. Document whether or not the discontinuation will have an adverse effect upon access to care for residents of the facility's market area.
- 2. Provide copies of notification letters sent to other resources or health care facilities that provide the same services as those proposed for discontinuation. The notification letter must include at least the anticipated date of discontinuation and the total number of patients that received care or the number of treatments provided during the latest 24 months.

APPEND DOCUMENTATION AS <u>ATTACHMENT 7</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION III. BACKGROUND

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

- 1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
- 2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
- 3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.
- 4. If, during a given calendar year, an applicant submits more than one application for permit or exemption, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS <u>ATTACHMENT 8</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 8.

SECTION IV. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for <u>ALL PROJECTS TO DISCONTINUE</u> A HEALTH CARE FACILITY OR CATEGORY OF SERVICE [20 ILCS 3960/5.4]:

- 1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
- 2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
- 3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

- 1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
- 2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
- 3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 9.

Safety Net I	nformation p	er PA 96-0031	
	CHARITY CA	RE	
Charity (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Charity (cost In dollars)			
Inpatient			
Outpatient			
Total			
	MEDICAID		
Medicald (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Medicaid (revenue)			
Inpatient			
Outpatient			

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD DISCONTINUATION APPLICATION FOR EXEMPTION- 08/2018 Edition

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APPLICATION FORM.					
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SECTION V. CHARITY CARE INFORMATION

- 1. All applicants and co-applicants shall indicate the amount of charity care for the latest three audited fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
- 2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
- 3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care <u>must</u> be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 10.

	CHARITY CARE		
	Year	Year	Year
Net Patient Revenue	_		
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS <u>ATTACHMENT 10</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.



I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

PRESENCE CHICAGO HOSPITALS NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 27, 1949, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 5TH day of NOVEMBER A.D. 2018.

Authentication #: 1830901492 verifiable until 11/05/2019 Authenticate at: http://www.cyberdriveillinois.com Desse White
SECRETARY OF STATE ATTACHMENT 1



I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

ALEXIAN BROTHERS-AHS MIDWEST REGION HEALTH CO., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 26, 2014, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



In Testimony Whereof, I hereto set

my hand and cause to be affixed the Great Seal of the State of Illinois, this 8TH day of NOVEMBER A.D. 2018 .

Authentication #: 1831202022 verifiable until 11/08/2019
Authenticate at: http://www.cyberdriveillinois.com

Desse White

SECRETARY OF STATE ATTACHMENT 1



I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

ASCENSION HEALTH, INCORPORATED IN MISSOURI AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON JUNE 27, 2011, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS IN THE STATE OF ILLINOIS.



In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 5TH day of NOVEMBER A.D. 2018.

Authentication #: 1830901614 verifiable until 11/05/2019
Authenticate at: http://www.cyberdriveillinois.com

Desse White
SECRETARY OF STATE ATTACHMENT 1



James L. Robinson III, PsyD.

President

Illinois Health Facilities and Services Review Board Springfield, IL

To Whom It May Concern:

I hereby attest that the site of Presence Saint Joseph Hospital-Chicago, that being 2900 North Lake Shore Drive, is owned by Presence Chicago Hospitals Network.

Sincerely,

lames L. Robinson III, PsyD

President

Notarized:

GERALBINE ESCAMILLA
Official Seal
Notary Public - State of Illinois
My Commission Expires Aug 11, 2019



I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

PRESENCE CHICAGO HOSPITALS NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 27, 1949, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

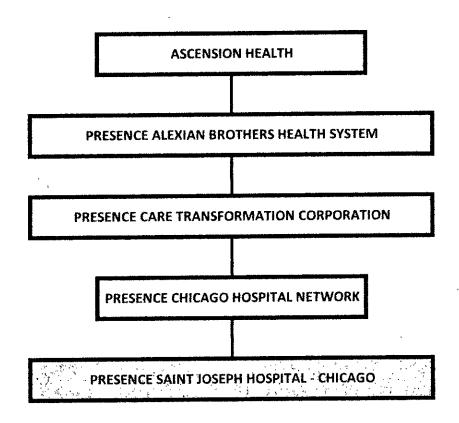


In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 5TH day of NOVEMBER A.D. 2018.

Authentication #: 1830901492 verifiable until 11/05/2019
Authenticate at: http://www.cyberdriveillinois.com

Desse White

SECRETARY OF STATE ATTACHMENT 3



DISCONTINUATION

- 1. Only the hospital's open heart surgery category of service is proposed to be discontinued through this Certificate of Exemption ("COE") application. No beds will be discontinued through this COE application.
- 2. No non-category of service clinical services are proposed to be discontinued as a result of the approval of this COE application.
- 3. The open heart surgery category of service will be discontinued within thirty days following the approval of the COE application addressing the discontinuation.
- 4. Presence Saint Joseph Hospital-Chicago designates one of its operating rooms for cardiovascular procedures. Following discontinuation, that OR will be used as a "general" OR, to be used by a number of specialties. A minimal amount of the hospital's equipment is used exclusively in conjunction with its open heart surgery program, and as appropriate, that equipment will be distributed to other AMITA Health hospitals.
- 5. Medical records will be retained by the hospital, consistent with all licensure and accreditation standards and requirements.
- 6. Not applicable, applies only to the discontinuation of an entire facility.
- 7. With the signatures on the Certification pages of this COE application, the applicants attest that notice of the category of service was published in the *Chicago Sun Times* on November 15, 2018. As of the filing of this COE application, the applicants are not aware of any responses to that notice. A copy of the notice is attached.

AMITA HEALTH PRESENCE HEALTH

Presence St Joseph Hosp

ADORDERNUMBER: 0001074006-01

PO NUMBER: Presence St Joseph Hosp

AMOUNT: 168.00

NO OF AFFIDAVITS:

LEGAL NOTICE

Presence Saint Joseph Hospital-Chicago intends to cease the operations of its open heart surgery program following receipt of approval to do so from the Illinois Health Facilities and Services Review Board ("IHFSRB"). It is anticipated that the discontinuation will occur before March 31, 2019. The hospital thends to file the required Certificate of Exemption application with the IHFSRB by December 15, 2018; after which time additional information relating to the proposed discontinuation can be found on the IHFSRB website at hisrb.illinois.gov.

Chicago Sun-Times
Certificate of Publication

State of Illinois - County of

Cook

Chicago Sun-Times, does hereby certify it has published the attached advertisments in the following secular newspapers. All newspapers meet Illinois Compiled Statue requirements for publication of Notices per Chapter 715 ILCS 5/0.01 et seq. R.S. 1874, P728 Sec 1, EFF. July 1, 1874. Amended by Laws 1959, P1494, EFF. July 17, 1959.

Formerly III. Rev. Stat. 1991, CH100, Pl.

Note: Notice appeared in the following checked positions.

PUBLICATION DATE(S): 11/15/2018

Chicago Sun-Times

IN WITNESS WHEREOF, the undersigned, being duly authorized, has caused this Certificate to be signed

by

Mary Lou Davis

Account Manager - Public Legal Notices

This 15th Day of November 2018 A.D.

AMITA HEALTH PRESENCE HEALTH 200 S WACKER DR ATTN: OLGA SOLARES CHICAGO, IL 60606

ATTACHMENT 5

REASONS FOR DISCONTINUATION

The primary reason for proposing the discontinuation of the hospital's open heart surgery program is low utilization. During both 2016 and 2017, only 46 cases were performed each year. And, with the advent of less-invasive procedures, volumes cannot reasonably be anticipated to increase.

November 14, 2018

VIA CERTIFIED MAIL RETURN RECEIPT REQUESTED

name title hospital street address city/state/ZIP code

> RE: Proposed Discontinuation of Open Heart Surgery Category of Service

Dear

This letter, addressing the subject above, is being sent in order to provide you an opportunity to submit an impact statement, should you choose to do so.

Presence Saint Joseph Hospital has suspended its open heart surgery category of service, and anticipates the formal discontinuation of that service to occur within thirty days following the Illinois Health Facilities and Services Review Board's ("IHFSRB's") approval of the hospital's Certificate of Exemption application to discontinue the category of service. That application will be filed prior to the end of this month.

During the 24-month period ending September 30, 2018, a total of 101 patients received open heart surgery at the hospital.

If you do elect to provide an impact statement, please include whether or not your hospital has any admission restrictions or limitations which would preclude it from providing open heart surgery services to residents from our service area. Any impact statement received will be forwarded to the IHFSRB. If you do not respond, we will assume that the discontinuation has no impact on your hospital.

Sincerely,

James L. Robinson III, PsyD President

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University of Illinois Hospital & Health Sciences System		
1740 West Taylor Street, Ste. 1400, M/C 693 Chicago, Illinois 60625-3642	☐ Insured Mail ☐ C.O.D.	eli selpt for Merchan
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ATTACHMENT 7

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Weis: Meinorial Hospital	
4646 ਮੁਤਾਹਾ Marine Drive	S. Service Type
Chicago, Illinois 60640-5759	☐ Certified Mail ☐ Express Mail ☐ Registered ☐ Return Receipt for Merchan ☐ insured Mail ☐ C.O.D.
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Northwestern Memorial Hospital	
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BACKGROUND

Ascension Health owns, operates and/or controls* the following Illinois licensed health care facilities:

AMITA Health Adventist Medical Center Bolingbrook Bolingbrook, IL IDPH #5496

AMITA Health Adventist Medical Center GlenOaks Glendale Heights, IL IDPH #3814

AMITA Health Adventist Medical Center Hinsdale Hinsdale, IL IDPH #0976

AMITA Health Adventist Medical Center La Grange La Grange, IL IDPH #5967

AMITA Health Alexian Brothers Medical Center Elk Grove Village Elk Grove Village, IL IDPH #2238

AMITA Health St. Alexius Medical Center Hoffman Estates Hoffman Estates, IL IDPH #5009

AMITA Health Alexian Brothers Behavioral Health Hospital Hoffman Estates, IL

Presence Holy Family Medical Center Des Plaines, IL

Presence Resurrection Medical Center Chicago, IL IDPH #6031

Presence Saint Francis Hospital Evanston, IL IDPH #5991

Presence Saint Joseph Hospital-Chicago Chicago, IL IDPH #5983 Presence Mercy Medical Center Aurora, IL IDPH #4903

Presence Saint Joseph Hospital-Elgin Elgin, IL IDPH #4887

Presence Saint Joseph Medical Center Joliet, IL IDPH #4838

Presence St. Mary's Hospital Kankakee, IL IDPH #4879

Presence Saint Mary of Nazareth Hospital Chicago, IL IDPH #6007

Presence Saint Elizabeth Hospital Chicago, IL IDPH #6007

Presence Lakeshore Gastroenterology Des Plaines, IL

Belmont/Harlem Surgery Center Chicago, IL IDPH #700313

^{*}per HFSRB definition



Mark A. Frey

President & Chief Executive Officer

AMITA Health System Office 2601 Navistar Dr. Lisle, IL 60532

224,273.2347 mark.frey@amitahealth.org

AMITA kealth org

Ms. Courtney Avery
Illinois Health Facilities
And Services Review Board
525 West Jefferson
Springfield, IL 62761

Dear Ms. Avery:

In accordance with Review Criterion 1110.230.b, Background of the Applicant, we are submitting this letter assuring the Illinois Health Facilities and Services Review Board that:

1. AMITA Health has not had any adverse actions against any facility owned, operated, and/or controlled by the applicant during the three (3) year period prior to the filing of this application, and

2. AMITA Health authorizes the State Board and Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1110.230.b or to obtain any documentation or information which the State

Board or Agency finds pertinent to this application.

If we can in any way provide assistance to your staff regarding these assurances or any other issue relative to this application, please do not hesitate to call me.

Sincerely,

President and

Chief Executive Officer

Date: 1 Clamber 8 , 2011

Notarized:

OFFICIAL SEAL
MELISSA KULIK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:06/13/22

pulson Kulk

SAFETY NET IMPACT STATEMENT

Presence Saint Joseph Hospital-Chicago has a long history of being a safety net provider, both in terms of services provided directly at or by the hospital, as well as its role in the community. The proposed discontinuation of open heart surgery services will have no impact on that commitment, nor will it have any impact on any other providers of safety net services.

Adventist Hinsdale Hospital

Section IV.

			64.204.7
Charity # of patients	FY 2015	FY 2016	FY 2017
Inpatient	75	73	146
Outpatient	513	421	1,610
Total	588	494	1,756
	FY 2015	FY 2016	FY 2017
Charity (cost in dollars)	909,758	941,159	513,833
Inpatient			561,760
Outpatient	822,738	770,058	
Total	1,732,496	1,711,217	1,075,593
Medicaid # of patients	FY 2015	FY 2016	FY 2017
Inpatient	1,365	1,204	1,404
Outpatient	44,634	25,405	30,905
Total	45,999	26,609	32,309
Medicaid (revenue)	FY 2015	FY 2016	FY 2017
Inpatient	27,417,603	14,175,204	13,190,650
Outpatient	7,843,260	10,385,734	9,624,655
Total	35,260,863	24,560,938	22,815,305

	FY 2015	FY 2016	FY 2017
Net Patient Revenue	283,527,840	301,668,355	311,985,334
Amount of Charity (charges)	6,828,478	6,248,091	3,968,482
Cost of Charity Care	1,732,496	1,711,217	1,075,593

Adventist La Grange Medical Center

Section IV.

	FY 2015	FY 2016	FY 2017
Charity # of patients	81	82	89
npatient	422	388	1,160
Outpatient	503	470	1,249
Total			
1 11	FY 2015	FY 2016	FY 2017
Charity (cost in dollars)	639,886	643,676	664,624
Inpatient	1,244,364	940,188	942,448
Outpatient	1,884,250	1,583,864	1,607,072
Total			
and the standard stan	FY 2015	FY 2016	FY 2017
Medicaid # of patients	824	741	885
Inpatient	12,578	12,005	16,073
Outpatient	13,402	12,746	16,958
Total			
	FY 2015	FY 2016	FY 2017
Medicaid (revenue)	9,456,596	9,643,426	6,888,00
Inpatient	4,306,103	4,122,811	6,323,81
Outpatient	13,762,699	13,766,237	13,211,81
Total			

	FY 2015	FY 2016	FY 2017
	159,802,351	160,571,704	158,971,897
Net Patient Revenue	7,637,693	6,375,572	6,565,635
Amount of Charity (charges)	1,884,250	1,583,864	1,607,072
Cost of Charity Care		<u> </u>	

Adventist Bolingbrook Hospital

Section IV.

	FY 2015	FY 2016	FY 2017
Charity # of patients	105	111	176
npatient	798	853	2,329
Outpatient	903	964	2,505
Total	300		
	FY 2015	FY 2016	FY 2017
Charity (cost in dollars)	737,726	640,020	564,434
Inpatient	1,506,569	1,126,392	1,000,180
Outpatient	2,244,295	1,766,412	1,564,614
Total			
	FY 2015	FY 2016	FY 2017
Medicaid # of patients	1,437	1,439	1,503
Inpatient	23,443	27,265	29,138
Outpatient	24,880	28,704	30,641
Total			
	FY 2015	FY 2016	FY 2017
Medicaid (revenue)	6,521,510	6,632,741	8,884,199
Inpatient	9,527,298	9,361,396	9,271,291
Outpatient	16,048,808	15,994,137	18,155,490
Total	10,040,000		

	FY 2015	FY 2016	FY 2017
		121,154,941	129,089,238
Net Patient Revenue	9,756,066	7,309,134	6,689,129
Amount of Charity (charges)	2,244,295	1,766,412	1,564,614
Cost of Charity Care		<u> </u>	

Adventist Glen Oaks Hospital

Section IV.

	FY 2015	FY 2016	FY 2017
Charity # of patients	112	110	102
npatient	715	803	1,328
Outpatient	827	913	1,430
Total			
1.45	FY 2015	FY 2016	FY 2017
Charity (cost in dollars)	765,891	675,725	718,114
Inpatient	1,592,189	1,362,203	1,099,263
Outpatient	2,358,080	2,037,928	1,817,377
Total			
The track of notionts	FY 2015	FY 2016	FY 2017
Medicaid # of patients	2,286	1,981	2,085
Inpatient	14,631	17,301	17,632
Outpatient	16,917	19,282	19,717
Total			
	FY 2015	FY 2016	FY 2017
Medicaid (revenue)	18,178,083	16,324,722	11,839,29
Inpatient	16,087,927	14,249,071	8,911,32
Outpatient	34,266,010	30,573,793	20,750,61
Total	1, 5,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	<u> </u>	

	FY 2015	FY 2016	FY 2017
	83,016,363	80,487,930	85,268,778
Net Patient Revenue	7.743,127	6,613,992	6,157,479
Amount of Charity (charges)	2,358,080	2,037,928	1,817,377
Cost of Charity Care			

Alexian Brothers Behavioral Health Hospital

Section IV.

ection IV.			7/2017
	FY 2015	FY 2016	FY 2017
harity # of patients	690	414	687
npatient	405	209	428
Outpatient	1,095	623	1,115
Total			
	FY 2015	FY 2016	FY 2017
Charity (cost in dollars)	418,356	461,258	543,631
Inpatient	296,690	185,059	200,688
Outpatient	715,046	646,317	744,319
Total	7.4-10-1-		
	FY 2015	FY 2016	FY 2017
Medicald # of patients	329	416	322
Inpatient	3,423	818	40,84
Outpatient	3,752	1,234	41,16
Total	<u> </u>		
	FY 2015	FY 2016	FY 2017
Medicaid (revenue)	649,000		723,60
Inpatient	1,679,000		1,872,01
Outpatient	2,328,000		
Total	2,520,000	1	

Section V			
	FY 2015	FY 2016	FY 2017
		76,916,399	78,615,801
Net Patient Revenue	1,993,961		1,919,198
Amount of Charity (charges)	715,046	646,317	744,319
Cost of Charity Care			

Alexian Brothers Medical Center

Section IV.

	FY 2015	FY 2016	FY 2017
Charity # of patients	311	125	399
npatient	3,008	1,477	2,232
Outpatient	3,319	1,602	2,631
Total	3,025		
	FY 2015	FY 2016	FY 2017
Charity (cost in dollars)	2,307,325	2,756,581	2,331,830
Inpatient	2,349,008	2,409,470	2,134,299
Outpatient	4,656,333	5,166,051	4,466,129
Total			
	FY 2015	FY 2016	FY 2017
Medicaid # of patients	1,074	3,806	2,410
Inpatient	41,044	49,428	45,946
Outpatient	42,118	53,234	48,356
Total			
	FY 2015	FY 2016	FY 2017
Medicaid (revenue)	13,668,000	24,917,316	14,688,808
Inpatient	8,288,000	14,100,420	12,104,570
Outpatient	21,956,000	39,017,736	26,793,378
Total	21,030,000	1 3-7	

	FY 2015	FY 2016	FY 2017
	449,261,000	457,943,000	472,013,000
Net Patient Revenue	23,820,931		23,058,353
Amount of Charity (charges)	4,656,333	5,166,051	4,461,129
Cost of Charity Care			

St. Alexius Medical Center

Section IV.

MOTEOD IV.			
ection iv.	FY 2015	FY 2016	FY 2017
harity # of patients	586	111	352
npatient	5,110	2,322	1,568
Dutpatient		7,136	6,105
	7,659	.,	
Total	FY 2015	FY 2016	FY 2017
Charity (cost in dollars)	2,214,865	2,574,992	1,876,626
Inpatient	3,053,373	2,994,694	2,201,842
Outpatient	5,268,239	5,569,686	4,078,468
Total	3,200,200		
	FY 2015	FY 2016	FY 2017
Medicald # of patients	3,190	5,233	3,870
Inpatient	40,829	57,423	56,410
Outpatient	50,178	51,762	51,803
Total			
	FY 2015	FY 2016	FY 2017
Medicaid (revenue)	24,916,000	24,335,000	26,698,588
Inpatient	15,813,000		19,870,05
Outpatient	40,729,000		46,568,64
Total			

Section V	FY 2015	FY 2016	FY 2017
	345,017,000	333,034,04	
Net Patient Revenue	27,143,649		21,730,913
Amount of Charity (charges)	5,268,239	5,569,686	4,078,468
Cost of Charity Care			

Presence St. Mary's Hospital

Section IV.

	FY 2015	FY 2016	FY 2017
harity # of patients	683	1,016	25
npatient	3,404	5,061	1,099
Outpatient	4,087	6,077	1,124
Total	4,007		
	FY 2015	FY 2016	FY 2017
Charity (cost in dollars)	1,178,589	1,143,754	263,568
Inpatient	2,058,972	1,063,567	647,661
Outpatient	3,237,561	2,207,321	911,229
Total			
	FY 2015	FY 2016	FY 2017
Medicaid # of patients	1,170	1,195	1,36
Inpatient	44,038	34,629	20,48
Outpatient	45,208	35,824	21,85
Total			
	FY 2015	FY 2016	FY 2017
Medicaid (revenue)	17,053,694	9,251,698	8,946,43
Inpatient	30,980,047	8,603,075	10,260,43
Outpatient	48,033,741	17,854,773	19,206,87
Total	1 40,030,142		<u> </u>

	FY 2015	FY 2016	FY 2017
	109,622,889	120,646,101	121,698,113
Net Patient Revenue	17,119,961	13,900,377	15,606,551
Amount of Charity (charges)	3,237,561	2,207,321	911,229
Cost of Charity Care		1	

Presence St. Joseph Medical Center

Section IV.

Charity # of patients	FY 2015	FY 2016	FY 2017
Inpatient	148	3,053	2,104
Outpatient	2,067	10,612	7,314
Total	2,215	13,665	9,418
Charity (cost in dollars)	FY 2015	FY 2016	FY 2017
Inpatient	1,223,021	4,528,712	3,763,727
Outpatient	2,127,121	2,780,350	4,085,625
Total	3,350,142	7,309,062	7,849,352
Medicaid # of patients	FY 2015	FY 2016	FY 2017
Inpatient	4,418	4,151	4,014
Outpatient	48,591	106,220	96,420
Total	53,009	110,371	100,434
Medicaid (revenue)	FY 2015	FY 2016	FY 2017
Inpatient	22,317,603	20,626,384	21,495,441
Outpatient	12,872,225	12,663,326	31,224,865
Total	35,189,828	33,289,710	52,720,306

	FY 2015	FY 2016	FY 2017
Net Patient Revenue	349,215,843	386,006,011	374,114,333
Amount of Charity (charges)	41,754,548	42,334,283	45,193,272
Cost of Charity Care	3,350,142	7,309,062	7,849,352

Presence St. Joseph Hospital-Elgin

Section IV.

ection iv.		FY 2016	FY 2017
f nationts	FY 2015		63
harity # of patients	683	1,199	
npatient	2,857	5,017	1,323
Outpatient	3,540	6,216	1,386
Total			
	FY 2015	FY 2016	FY 2017
Charity (cost in dollars)	1,659,661	2,150,613	678,071
Inpatient	2,522,152	1,239,628	1,919,060
Outpatient	4,181,813	3,390,241	2,597,131
Total			
	FY 2015	FY 2016	FY 2017
Medicaid # of patients	915	846	1,165
Inpatient	22,401	28,782	33,195
Outpatient	23,316	29,628	34,360
Total			
	FY 2015	FY 2016	FY 2017
Medicaid (revenue)	11,609,548	8,499,358	9,376,28
Inpatient	19,114,352	4,899,091	5,259,63
Outpatient	30,723,900		14,635,91
Total	30,, 20,000		

	FY 2015	FY 2016	FY 2017
		148,323,931	143,143,526
Net Patient Revenue	21,617,399		
Amount of Charity (charges)	4,181,813	3,390,241	2,597,131
Cost of Charity Care			

Presence Mercy Medical Center

Section IV.

ection IV.	FY 2015	FY 2016	FY 2017
harity # of patients	1,204	1,988	147
		6,732	2,077
npatient Outpatient	4,078	8,720	2,224
	5,282	0,7201	
otal		FY 2016	FY 2017
Charity (cost in dollars)	FY 2015 2,293,444	2,853,889	1,240,933
npatient	3,128,539	3,166,129	2,125,573
Outpatient	5,421,983	6,050,491	3,366,506
Total	3,123,000		
	FY 2015	FY 2016	FY 2017
Medicaid # of patients	2,273	1,826	2,477
Inpatient	55,196	45,825	64,057
Outpatient	57,469	47,651	66,534
Total			
	FY 2015	FY 2016	FY 2017
Medicald (revenue)	16,138,639	13,345,368	14,378,74
Inpatient	41,136,666		17,501,74
Outpatient	57,275,305		31,880,49
Total	31,213,000		

Jection .			
	FY 2015	FY 2016	FY 2017
		185,662,250	191,487,648
Net Patient Revenue	29,885,457		38,791,796
Amount of Charity (charges)	5,421,983	6,050,491	
Cost of Charity Care	-,		

Presence Resurrection Medical Center

Section IV.

	FY 2015	FY 2016	FY 2017
Charity # of patients	765	768	66
inpatient	3,845	6,081	890
Outpatient	4,610	6,849	956
Total	7,020		
	FY 2015	FY 2016	FY 2017
Charity (cost in dollars)	2,563,124	1,173,755	686,843
Inpatient	1,929,857	2,189,381	825,415
Outpatient	4,492,981	3,363,136	1,512,258
Total	1 1,10-7-3-1		
	FY 2015	FY 2016	FY 2017
Medicaid # of patients	601	387	378
inpatient	13,200	6,737	21,852
Outpatient	13,801	7,124	22,230
Total			
	FY 2015	FY 2016	FY 2017
Medicaid (revenue)	(2,406,200)	6,232,260	67,975,604
Inpatient	3,702,310	3,629,433	37,801,109
Outpatient	1,296,110	9,861,693	105,776,713
Total	1	<u> </u>	

	FY 2015	FY 2016	FY 2017
Para la	257,729,252	264,576,914	270,126,791
Net Patient Revenue	22,922,240	18,571,646	15,804,220
Amount of Charity (charges)	4,492,981	3,363,136	1,512,258
Cost of Charity Care		<u> </u>	

Presence Holy Family Medical Center

Section IV.

	FY 2015	FY 2016	FY 2017
Charity # of patients	30	133	5
Inpatient	1,369	552	52
Outpatient	1,399	685	57
Total			
	EV 2015	FY 2016	FY 2017

	FY 2015	FY 2016	FY 2017
Charity (cost in dollars)	316,123	350,291	555,325
Inpatient	144,232	82,536	49,475
Outpatient	460,355	432,827	604,800
Total	_ <u></u>		

	FY 2015	FY 2016	FY 2017
Medicald # of patients	123	45	52
Inpatient	304	815	4,371
Outpatient	427	860	4,423

	FY 2015	FY 2016	FY 2017
Medicaid (revenue)	(2,347,748)	5,554,348	27,387,711
Inpatient	627,226	1,033,372	4,330,314
Outpatient		6,587,720	31,718,025
Total			

	FY 2015	FY 2016	FY 2017
			70,564,615
Net Patient Revenue	1,561,868	2,255,868	4,544,910
Amount of Charity (charges) Cost of Charity Care	460,355	432,827	604,800

Presence St. Francis Hospital

Section IV.

	FY 2015	FY 2016	FY 2017
harity # of patients	611	628	71
npatient	3,898	6,885	1,212
Outpatient	4,509	7,513	1,283
Total	",000		
	FY 2015	FY 2016	FY 2017
Charity (cost in dollars)	1,824,721	1,652,766	540,676
Inpatient	2,807,049	2,390,180	901,814
Outpatient	4,631,770	4,042,946	1,442,490
Total	1,000		
	FY 2015	FY 2016	FY 2017
Medicaid # of patients	1,068	621	630
Inpatient	13,374	7,080	19,965
Outpatient	14,442	7,701	20,595
Total		<u></u>	
	FY 2015	FY 2016	FY 2017
Medicaid (revenue)	8,028,798	12,338,025	31,418,703
Inpatient	12,825,638	7,584,914	25,782,125
Outpatient	20,854,436		57,200,828
Total	20,03-1,-100	1	

	FY 2015	FY 2016	FY 2017
- Paragraphic	164,750,924	167,195,901	174,967,222
Net Patient Revenue	21,880,375		18,229,097
Amount of Charity (charges)	4,631,770	4,042,946	1,442,490
Cost of Charity Care		<u> </u>	

Presence St. Joseph Hospital-Chicago

FY 2015 FY 201	16	FY 2017
# of patients 794	723	42
ent 2,531 4	,445	452
	,168	494
5,022 }		
FY 2015 FY 20	16	FY 2017
y (cost in dollars) 1,437,204 72	7,799	354,365
ent 1,691,249 1,520	0,340	454,772
	8,139	809,137
J, LEU, 130 1		
FY 2015 FY 2	016	FY 2017
caid # of patients 786	464	427
ient 6,397	3,000	10,530
atient 7,183	3,464	10,96
1,7		
	2016	FY 2017
	16,947	33,379,54
		18,530,76
3,327,1-		51,910,31
tient 9,517,71 patient 18,818,32		

Section A			
	FY 2015	FY 2016	FY 2017
		207,300,397	218,077,373
Net Patient Revenue	10,750,603		
Amount of Charity (charges)		2,248,139	
Cost of Charity Care	3,128,453	2,240,133	<u></u>
Cost of Charty Care			

Presence Saint Mary of Nazareth and Saint Elizabeth Hospitals

Section IV.

Ol - Au H of action to	FY 2015	FY 2016	FY 2017
Charity # of patients	1,213	985	173
Inpatient	6,969	12,243	2,531
Outpatient		13,228	2,704
Total	8,182	13,220	2,704
Charity (cost in dollars)	FY 2015	FY 2016	FY 2017
Inpatient	4,380,283	2,542,044	1,389,711
Outpatient	4,421,583	4,423,868	1,951,885
Total	8,801,866	6,965,912	3,341,596
Medicaid # of patients	FY 2015	FY 2016	FY 2017
Inpatient '	3,639	1,918	1,926
Outpatient	27,255	12,046	73,984
Total	30,894	13,964	75,910
	FY 2015	FY 2016	FY 2017
Medicaid (revenue)	40,340,734	47,951,568	45,807,382
Inpatient			24,334,912
Outpatient	45,164,598	24,498,704	
Total	85,505,332	72,450,272	70,142,294

	FY 2015	FY 2016	FY 2017
Net Patient Revenue	303,495,761	304,924,151	331,806,223
Amount of Charity (charges)	39,232,810	36,373,058	28,512,920
Cost of Charity Care	8,801,866	6,965,912	3,341,596

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

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ATTACHMEN NO.	т	PAGES
1	Applicant Identification including Certificate of Good Standing	17
2	Site Ownership	20
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Axel & Associates, Inc.

MANAGEMENT CONSULTANTS

F-070-18

by FedEX

December 19, 2018

Ms. Courtney Avery Administrator Illinois Health Facilities and Services Review Board 525 West Jefferson Springfield, IL 62761

Dear Ms. Avery:

Enclosed please find two copies of a Certificate of Exemption ("COE") application addressing the discontinuation of the open heart surgery category of service at Presence saint Joseph Hospital-Chicago.

The application is accompanied by a check, in the amount of \$2,500.00, as a filing fee.

Should any additional information be required, please do not hesitate to contact me.

Sincerely,

Tacob M. Axel

President

enclosures